PRINTED: 04/02/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G188	A. BUILDING _____ B. WING _____	C 03/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE	3259 'O' ST, SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On March 13, 2008 at approximately 10:10 AM this office received a complaint via telephone from neighbors in the community. The neighbors alleged that bulk trash was observed for approximately two weeks on the curb-side. An onsite visit was initiated on March 17, 2008. The findings of the investigation were based on observations at the group home, interviews with complaints, the staff at the group home, as well as a review of records. Although the investigation failed to substantiate any violation of the law of federal regulations to support the allegations. Incidental findings revealed that the facility's Governing Body was not in compliance with federal regulations.	W 000	W000 ILS HAS PUT A BULK TRASH PROTOCOL IN A PLACE TO ENSURE COMPLIANCE WITH FEDERAL REGULATIONS.	4/10/08
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review, the Governing Body failed to ensure its Incident Management System Policy and Procedures were followed with regards to incident reporting services of law enforcement or emergency personnel by a staff for one of the five clients in the facility. (Client #1) The finding includes: Review of incident reports on March 17, 2008 at approximately 11:30 AM revealed that Client #1 left the facility without permission and walked down the street. Staff followed the client while	W 104		

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 APR 11 P 1:45

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

EXECUTIVE DIRECTOR 4/10/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 another staff person called non-emergency (311). While the client was walking down the street, a Police Patrol car was coming down the street. The Police Officer spoke to the client and directed her into the facility. At that time the staff called and cancelled the 311 call. Review of the facility's "Incident Management System Policy and Procedures" required the staff to report all incidents of law enforcement or emergency personnel to Department of Health/Health Regulations Administration (DOH/HRA). Review of records failed to provide evidence that DOH/HRA had been notified of the incident. Interview with the Qualified Mental Retardation Professional on March 19, 2007 at 2:00 PM acknowledged that the DOH had not been notified of the incident because the client was not taken away in the service vehicle.	W 104	W104 INSERVICE TRAINING ON INCIDENT REPORTING WAS DONE. ILS WILL CONTINUE TO ENSURE THAT ALL INCIDENTS REQUIRING LAW ENFORCEMENT OR EMERGENCY PERSONEL ARE REPORTED TO DOH/HRA.	4/10/08

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I 000	INITIAL COMMENTS On March 13, 2008 at approximately 10:10 AM this office received a complaint via telephone from neighbors in the community. The neighbors alleged that bulk trash was observed for approximately two weeks on the curb-side. An onsite visit was initiated on March 17, 2008. The findings of the investigation were based on observations at the group home, interviews with complaints, the staff at the group home, as well as a review of records. Although the investigation failed to substantiate any violation of the law of federal regulations to support the allegations. Incidental findings revealed that the facility's Governing Body was not in compliance with federal regulations.	I 000	1000 SEE W000	4/10/08
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on record review, the Governing Body failed to ensure its Incident Management System Policy and Procedures were followed with regards to incident reporting services of law enforcement or emergency personnel by a staff	I 379		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE EXECUTIVE DIRECTOR (X6) DATE 4/10/08

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I 379	Continued From page 1 for one of the five residents in the facility. (Resident #1) The finding includes: Review of incident reports on March 17, 2008 at approximately 11:30 AM revealed that Resident #1 left the facility without permission and walked down the street. Staff followed the resident while another staff person called non-emergency (311). While the resident was walking down the street, a Police Patrol car was coming down the street. The Police Officer spoke to the resident and directed her into the facility. At that time the staff called and cancelled the 311 call. Review of the facility's "Incident Management System Policy and Procedures" required the staff to report all incidents of law enforcement or emergency personnel to Department of Health/Health Regulations Administration (DOH/HRA). Review of records failed to provide evidence that DOH/HRA had been notified of the incident. Interview with the Qualified Mental Retardation Professional on March 19, 2007 at 2:00 PM acknowledged that the DOH had not been notified of the incident because the client was not taken away in the service vehicle.	I 379	W1379 SEE W104	4/10/08